LOUISVILLE METRO PUBLIC HEALTH & WELLNESS

**SITE:**_____

H1N1 Influenza Vaccine ADMINISTRATION RECORD

**NAME:** _____ **PHONE NUMBER:** _____

**ADDRESS:**_____
STREET CITY COUNTY STATE ZIP

**AGE**_____ **BIRTHDATE:** _____/_____/_____
MONTH DAY YEAR

**RACE:** (Check ONE or MORE) □ **(W)** White □ **(B)** Black or African American □ **(N)** American Indian or Alaska Native □ **(A)** Asian □ **(H)** Native Hawaiian or Other Pacific Islander **ETHNICITY:** Hispanic or Latino **(Y)** Yes or **(N)** No
**SEX:** (Check ONE) □ Male □ Female

**YOUR (or your child's) DOCTOR'S NAME:**_____

**Y N**

□ □ Do you have a serious allergy to eggs?
□ □ Do you have any other serious allergies? Please list_____
□ □ Have you ever had a serious reaction to a previous dose of flu vaccine?
□ □ Have you ever had Guillain-Barre Syndrome (a temporary severe muscle weakness) within 6 weeks after receiving a flu shot?
□ □ Have you been vaccinated within the past 30 days? Vaccine_____ Date_____
□ □ Have you had a flu vaccination within the past 30 days? Flu shot____Intranasal Vaccine (nasal mist)____
□ □ Do you have any of the following: asthma, diabetes, disease of the lungs, heart, kidneys, liver, nerves, or blood?
□ □ Do you have a weak immune system (HIV, cancer, or medications such as steroids or those used to treat cancer)?
□ □ Are you pregnant?
□ □ Do you have close contact with a person who is immune compromised? (example: someone who has recently had a bone marrow transplant)?
□ □ If this vaccine is for your child, are they on long-term aspirin or aspirin containing therapy (does your child take aspirin every day)?

Louisville Metro Department Public Health Wellness may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. **I am not responsible for any charges for the H1N1 influenza vaccine or administration.**

**I have read or have had explained to me the 2009-2010 Vaccine Information Statement (VIS) and understand the risks and benefits for the:**

**( ) 2009-2010** *Inactivated* ***H1N1 influenza vaccine, (*VIS dated 10/2/09)**
**( ) 2009-2010** *Live****, Intranasal H1N1 influenza vaccine, (*VIS dated 10/2/09)**

**X**_____ **DATE:** _____
**Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian)**

**FOR Louisville Metro Department of Public Health and Wellness USE ONLY**

Vaccine Manufacturer:_____ Vaccine Lot Number:_____

Injection Site:_____

Signature and Title of Provider: _____
NOTES: _____